Massage Intake Form

Personal Information

Name _____ DOB _____ Pronouns _____

Address _____ City/State/Zip _____

Phone_____ Email_____

Occupation: _____ Do you accept text messages? Yes No

Do you see a chiropractor? Yes No How did you hear about me?_____

Emergency Contact _____ Phone _____

Medical Information

Have you ever had a professional massage before? ☐ Yes ☐ No If yes, how long ago: _____

What pressure do you prefer: ☐ Light ☐ Medium ☐ Deep

Are you currently pregnant? ☐ yes ☐ no If yes, how far along? _____

Are you taking any medications? ☐ yes ☐ no If yes, please list name and use:

_____

_____

Do you suffer from chronic pain? ☐ yes ☐ no If yes, please explain _____

What makes it better? _____What makes it worse?_____

Have you had any orthopedic injuries or joint replacements? ☐ yes ☐ no If yes, please list:

_____

List of surgeries (type & date):_____

_____

Please indicate any of the following that apply to you:

☐ Infection/fever	☐ Tumors	☐ Blood Clots	☐ Cellulitis
☐ Cancer/Chemo	☐ Heart attack/stroke	☐ Kidney Issues	☐ CHF
☐ Jaw pain	☐ Ringing or pain in ears	☐ Grinding Teeth	☐ Vertigo
☐ Autoimmune	☐ Thyroid issues	☐ Multiple Sclerosis	☐ Diabetes
☐ Digestive issues	☐ Sprains/Strains	☐ Arthritis/Joint problems	☐ Neuropathy
☐ Osteoporosis	☐ High/Low Blood Pressure	☐ Fibromyalgia	☐ Pacemaker
☐ Varicose Veins	☐ Lymph nodes removed	☐ Numbness/Tingling	☐ Headaches
☐ Skin condition: rash, warts, hives,other		☐ Hernia	☐ Ulcer

Please explain any conditions marked above:_____

_____

Do you have any allergies or sensitivities (nut oils, essential oils, scents)? ☐ yes ☐ no

If yes, please list: _____

Are there any areas (feet, face, abdomen, glutes, pectoral muscles, groin, etc.) you DO NOT want massaged? ☐ yes ☐ no If yes, please explain:_____

What are your goals/reason for this treatment session? ☐ Relaxation ☐ Pain Relief ☐ Both

What position(s) do you sleep at night? (Mark all that apply)

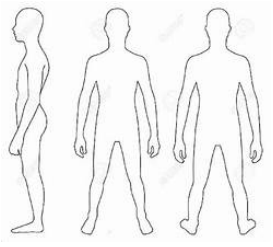
☐ Back ☐ Stomach ☐ Right side ☐ Left side

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Daily

Do you drink caffeine? ☐ Never ☐ Occasionally ☐ Daily How many per day? _____

Do you exercise? ☐ Never ☐ Occasionally ☐ Daily Type of exercise: _____

Please shade your areas of discomfort:



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**** Appointment Cancellation, No Show and Timeliness Policy****
Should you need to cancel, reschedule or change your scheduled appointment, please do so a minimum of 24 hours prior to your appointment. Your full session fee will be forfeited if you fail to provide adequate notice or miss your appointment altogether. If the appointment was booked under a gift certificate, it will be voided in lieu of the fee.

In order to meet the needs of all clients, every session will begin and end on time. If you arrive late for your scheduled appointment, your session will be modified to fit within the time remaining. If you are more than 15 minutes late, your session may be marked as a missed appointment.

I reserve the right to terminate treatment at any time. This includes, but is not limited to, multiple cancellations, appointment changes and no-shows.
Client Signature _____ Date _____

*** Should you have a medical issue in between sessions, please notify me as soon as possible so I can determine if you should return for or postpone your next appointment. (Example.:car accident, falling, vaccinations, illness, medical procedure, new diagnosis, new medications, etc).
Client Signature _____ Date _____

Liability Release and Consent for Treatment
By signing below, you agree to the following:
1) I give my permission to receive massage therapy.
2) I understand that therapeutic massage is not a substitute for traditional medical treatment or medications. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.
3) I have clearance from my physician to receive massage therapy.
4) I understand the risks associated with massage therapy include, but are not limited to:
• Superficial bruising • Short-term muscle soreness • Exacerbation of undiscovered injury. I therefore release the individual massage therapist from all liability concerning these injuries that may occur during the massage session.
5) I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.
6) I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.
7) I understand that I or the massage therapist may terminate the session at any time
8) I understand that I must pre-pay in order to schedule any session.
9) I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.
Understanding all of this, I give my consent to receive care and release and hold harmless,
Laurie Geest, LMT LLC from any claims thereto.
Client Signature _____ Date _____
Therapist Signature _____ Date _____

Information & Suggestions
· Prior to your massage, please remove all jewelry and pull long hair back with a clip or band
· In general, massage is given while you are unclothed. However, you may choose to wear undergarments. You will be covered with a top sheet throughout your session.
· Feel free to ask your therapist any questions before, during or after the session